CHAPTER 517 - COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR PERSONAL CARE SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	XXXX	January 1, 2014

Table of Contents

Topic		Page Number
Introduction		4
517.1	Definitions	4
517.2	Program Description	8
517.3	Provider Certification	8
517.3.1	Office Criteria	9
517.4	Continuing Certification	10
517.5	Record Requirements	10
517.5.1	Member Records	10
517.5.2	Personnel Records	11
517.6	Provider Certification Reviews	11
517.7	Member Record Reviews	12
517.8	Direct Care Staff Training Requirements	12
517.8.1	Annual Staff Training	13
517.8.2	Training Documentation	14
517.9	Registered Nurse Qualifications	14
517.10	Criminal Investigation Background Checks	14
517.11	Voluntary Agency Closure	16
517.12	Involuntary Agency Closure	16
517.13	Additional Sanctions	16
517.14	Incident Management	17
517.14.1	Incident Management Documentation & Investigation Procedures	18
517.14.2	Incident Management Tracking and Reporting	19
517.15	Personal Care Services	19
517.16	Location of Services	19
517.16.1	Assisted Living Residences and Group Residential Facilities	20
517.17	Services and/or Costs Not Eligible For Reimbursement Under Personal Care Services	20

517.18	Family Member Restriction	21
517.19	Member Eligibility	21
517.19.1	Medical Eligibility Determination	21
517.19.2	Medical Eligibility Criteria for Personal Care Services	21
517.19.3	Service Level Criteria	22
517.19.4	Service Level Limits	23
517.20	Results of PAS Evaluation	23
517.21	Covered Services	24
517.21.1	Initial Member Assessment/Reevaluation	25
517.21.2	Ongoing RN Assessment and Care Planning	25
517.21.3	Personal Care Services (Direct Care Services)	26
517.22	Provision of Dual Services	27
517.22.1	Dual Service Provision for ADW Members	27
517.22.2	Dual Service Provision for I/DDW Members	28
517.22.3	Dual Service Provision for TBIW Members	29
517.23	Members Rights and Responsibilities	30
517.24	Transfer to Different Agency	31
517.25	Discontinuation of Services	31
517.26	Member Grievance Process	32
518.00	How to Obtain Information	34

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of Personal Care services provided to eligible West Virginia Medicaid members.

The policies and procedures set forth herein are regulations governing the provision of Personal Care services by Personal Care providers in the Medicaid Program administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of *Title XIX* of the *Social Security Act* and *Chapter 9* of the *Public Welfare Law of West Virginia*.

All forms for this program can be found at http://www.dhhr.wv.gov/bms/Pages/default.aspx.

517.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to Common Chapter 200, *Acronyms and Definitions*, of the Provider Manual. In addition, the following definitions apply to the requirements for payment of services in the Personal Care Program described in this chapter.

Abuse: the infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADLs): activities that a person ordinarily performs during the course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Anchor Date: the annual date by which the member's eligibility for continuing Personal Care services must be recertified. Anchor Date will be the first of the month in which the member's PAS determined medical eligibility.

Assisted Living Residence: any living facility, residence or place of accommodation, however named, available for four or more residents which is advertised, offered, maintained or operated by the ownership or management, whether for payment or not, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care as defined in the State Code §16-5D-1.

Behavioral Health Center: any inpatient, residential or outpatient facility for the care and treatment of persons with mental illness, intellectual/developmental disabilities or addiction which is operated, or licensed to operate, by the Department of Health and Human Resources.

Certificate of Need (CON): a regulatory program originally enacted in 1977 which reviews and determines the need for certain medical services, the financial feasibility, and whether the service(s) is consistent with the WV State Health Plan. For more information on the CON process please see the West Virginia Healthcare Authority web page.

Community Integration: the full participation of all people in community life.

Competency Based Curriculum: a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas.

Direct Access: physical contact with a resident or beneficiary or access to the resident or beneficiary's property, personally identifiable information, or financial information.

Direct Care Staff: the individuals who provide the day-to-day care to Personal Care members.

Dual Services: when a Medicaid member is receiving Medicaid Waiver services and Personal Care services at the same time.

Emergency Plan: a written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural, medical or man-made incident.

Environmental Maintenance: activities such as light house cleaning, making and changing the member's bed, dishwashing, and member's laundry.

Felony: a serious criminal offense punishable by imprisonment in a correctional facility.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other document.

Fiscal Agent: agency contracted by the Bureau for Medical Services to verify coverage, prior authorization requirements, service limitations and practitioner information as well as pay claims.

Group Residential Facility: a facility which is owned, leased or operated by a behavioral health service provider and which provides residential services and supervision for members who are developmentally or behaviorally disabled**.**

Home and Community Based Services (HCBS): services which enable Medicaid members to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Informal Supports: family, friends, neighbors or anyone who provides a service to a Medicaid member but is not reimbursed.

Instrumental Activities of Daily Living (IADLs): skills necessary to live independently, such as the ability to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Representative: a personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Member: a person who is eligible for Medicaid services.

Minor Child: a child under the age of 18.

Misdemeanor: a less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail.

Neglect: "the failure to provide the necessities of life to an incapacitated adult or child" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or child (WV State Code §9-6-1). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Operating Agency: the agency contracted by the Bureau for Medical Services, to manage the Personal Care Program. The Operating Agency is responsible for approving providers who have a valid Certificate of Need, assisting with member transfers when requested, monitoring and reviewing Personal Care agencies and conducting member case reviews.

Person-Centered Planning: a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.

Quality Management Plan: a written document which defines the acceptable level of quality, and describes how the provider will ensure this level of quality in its deliverables and work processes.

Remediation: act of correcting an error or a fault.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Residential Care Community: any group of seventeen (17) or more residential apartments, however named, which are part of a larger independent living community and which are advertised, offered, maintained or operated by an owner or manager, regardless of payment for the expressed or implied purpose of providing residential accommodations, personal assistance and supervision on a monthly basis to 17 or more persons who are or may be dependent upon the services of others by reason of physical or mental impairment or who may require limited and intermittent nursing care who are capable of self-preservation and are not bedfast.

Scope of Services: the range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Self-Preservation: Protection of oneself from harm or destruction.

Sexual Abuse: any act towards an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1) Sexual intercourse/intrusion/contact; and
2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or child, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Specialized Family Care Provider (SFCP): an individual who operates a foster-care home which has received certification through the WVDHHR Specialized Family Care Program. Both the home and the individual providing services must be certified by a Specialized Family Care Family Based Care Specialist.

Utilization Management Contractor (UMC): the contracted agent of the Bureau for Medical Services, who receives requests for Personal Care Services, determines eligibility and issues prior authorizations for Personal Care services.

517.2 PROGRAM DESCRIPTION

Personal Care services are available to assist an eligible member to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the member's home, place of employment or community. To be medically eligible for Personal Care services, Medicaid members must have three (3) deficits and require hands-on assistance/supervision/cueing in ADLs/IADLs ordered by a physician and be provided by a qualified Personal Care provider(s). Members can receive a maximum of two hundred and ten (210) hours per month based on assessed needs. Services may not solely involve ancillary tasks such as housekeeping or assistance with chores. There are no age restrictions for members of Personal Care services.

517.3 PROVIDER CERTIFICATION

In order to provide Personal Care services under West Virginia Medicaid, a provider agency must have a Certificate of Need (CON) from the WV Health Care Authority. Exempt from this provision are Senior Centers, WV licensed Comprehensive Behavioral Health Care Centers, and Specialized Family Care Providers.

After receiving a CON from the WV Health Care Authority, Personal Care provider applicants (excluding Specialized Family Care Providers) must submit a Certification Application to the Operating Agency.

In addition, applicants must submit and maintain the following:

A. A valid Certificate of Need (CON);
B. A business license issued by the State of West Virginia;
C. A federal tax identification number (FEIN)
D. A competency based curriculum for required training areas for direct care staff *(Chapter 517.8 and its subparts.);*
E. An organizational chart;
F. A list of the Board of Directors (if applicable);
G. A list of all provider staff, which includes their qualifications. *(Chapter 517.5, Chapter 517.8, Chapter 517.9 and Chapter 517.10 and all of their subparts);*
H. A list of county or counties served:

I. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances.
J. A physical office that meets the criteria outlined in *Chapter 517.3.1;*
K. Written policies and procedures for processing member grievances;
L. Written policies and procedures for processing member and staff complaints;
M. Written policies and procedures for member transfers;
N. Written policies and procedures for the discontinuation of member services;
O. Written policies and procedures to avoid conflict of interest;
P. Office space that allows for member confidentiality; and
Q. An Agency Emergency Plan (for members and for office operations).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

Following the receipt of a completed Certification Application, the Operating Agency will schedule an onsite review to verify that the applicant meets the certification requirements outlined above. Upon satisfactory completion of the onsite review, the BMS fiscal agent will provide the applicant with an enrollment packet, including the Provider Agreement. The applicant must return the Provider Agreement signed by an authorized representative to BMS. After reviewing and signing the Provider Agreement BMS will return a copy to the applicant and forward a copy to the fiscal agent. The fiscal agent will assign a provider number and send a letter informing the provider that it may begin providing and billing for Personal Care services. **No Personal Care services may be billed by a provider until receipt of this letter.** A copy of this letter is also sent to the Operating Agency.

517.3.1 OFFICE CRITERIA

Personal Care providers (excluding Specialized Family Care Providers) must designate and staff at least one physical office location. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. Be located in West Virginia;
B. Meet Americans with Disabilities Act requirements for accessibility (Refer to 28 CFR 36, as amended);
C. Be readily identifiable to the public;
D. Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone);
E. Maintain a secure (Health Insurance Portability and Accountability Act (HIPAA) compliant) e-mail address for communication with BMS and the Operating Agency;
F. Have hours posted in a visible area showing the business is open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion;

G. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800(A), General Administration*, and *Common Chapter 300, Provider Participation Requirements*, for more information on maintenance of records); and
H. Maintain a 24-hour contact method.

When a provider is physically moving their agency to a new location, opening a satellite office, and/or proposing to expand services into another county, they must notify the Operating Agency **prior** to the change. The Operating Agency will schedule an on-site review of any new office location from which members will be served to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified.

517.4 CONTINUING CERTIFICATION

Once certified and enrolled as a Medicaid provider, Personal Care providers must continue to meet the requirements listed in *Section 517.3 and its subparts* as well as the following:

A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards as set forth in *Chapter 517.8, Chapter 517.9 and Chapter 517.10* and all of their subparts (excluding Specialized Family Care providers);
B. Provide services based on each member's individually assessed needs, including evenings and weekends;
C. Maintain adequate documentation demonstrating the time, place, and services administered, and records that demonstrate compliance with state and federal regulations, including this chapter.
D. Furnish information to BMS, or its designee, as requested. (Refer to *Common Chapter 800(A), General Administration*; *Common Chapter 800(B), Quality and Program Integrity;* and *Common Chapter 300, Provider Participation Requirements* for more information on maintenance of records;
E. Maintain a current list of members receiving Personal Care services; and
F. Comply with the Incident Management System (*Chapter 517.14 and its subparts*) and maintain an administrative file of Incident Reports.

517.5 RECORD REQUIREMENTS

Providers must meet the following record requirements:

517.5.1 MEMBER RECORDS

A. The provider must keep a file on each Medicaid member for whom the Department of Health and Human Resources is billed. Member files must contain all original and/or required documentation for services provided to the member including documentation supporting the Pre-Admission Screening (PAS), Member Assessments, Contact Notes, Plan of Care, Daily Logs, etc. Required on-site documentation may be maintained in an electronic format in accordance with Common Chapter 300, Section 320.5.

B. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

517.5.2 PERSONNEL RECORDS

A. Original and legible copies of personnel documentation including training records, licensure, confidentiality agreements, Criminal Investigation Background checks (CIB) *(Chapter 517.10),* etc. must be maintained on file by the certified provider. (For Specialized Family Care providers, the Bureau for Children and Families will maintain these files.)
B. Minimum credentials for professional staff must be verified upon hire and thereafter based upon their individual professional license requirements.
C. All documentation on each staff member must be kept by the Medicaid provider in the designated office that represents the county where services were provided.
D. Verification that OIG Medicaid Exclusion List was checked as appropriate for the position as well as the WV DHHR Protective Services Record check.

In regards to all records, Certified Personal Care providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Personal Care Program as well as requirements described in Common *Chapter 100, General Information*; Common *Chapter 300, Provider Participation; and* Common *Chapter 800(A), General Administration* of the Provider Manuals. These can be found at the BMS Web Site (http://www.dhhr.wv.gov/bms/Pages/ProviderManuals.aspx). Providers must also agree to make themselves, Board Members, their staff, and any and all records pertaining to member services and personnel records available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

517.6 PROVIDER CERTIFICATION REVIEWS

The following applies only to providers who must meet the Operating Agency certification standards listed in *Chapter 517.3* and its subparts.

Providers are required to submit designated evidence to the Operating Agency every 12 months to document continuing compliance with all certification requirements as specified under *Chapter 517.3* and all of its subparts. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not received by the Operating Agency either prior to or on the established date a pay hold may be placed on the provider's claims until documentation is received. If after 60 days, documentation is not received steps may be taken to execute an emergency transfer of Personal Care members. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by the Operating Agency staff.

The Operating Agency will review all submitted certification documentation and provide a report to BMS. BMS may request payback for any of the certification requirements which are not met. The provider must remove employees who do not meet requirements from member homes until certification standards are met and submit required documentation to the Operating Agency. If the documentation is not received within 30 days of the request BMS may:

- Place a payment hold on all future claims until the provider can prove they meet all certification requirements; and
- Terminate the provider's participation as a Personal Care provider if all issues are not resolved within 60 calendar days of request.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

517.7 MEMBER RECORD REVIEWS

The Operating Agency will review member records using the Personal Care Monitoring tool. This tool is available on the Operating Agency's website. A representative random sample will also be utilized to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when a member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider within 30 calendar days. Providers will have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

517.8 DIRECT CARE STAFF TRAINING REQUIREMENTS

Medicaid prohibits the spouse of a member or parents of a minor child (under the age of 18) from providing Personal Care services for purposes of reimbursement.

All Personal Care direct care staff, including Specialized Family Care Providers, must be at least 18 years of age. All Personal Care direct care staff, including Specialized Family Care Providers, must have the following competency based training before providing service:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the provider agency nurse who is a certified CPR instructor, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by the Operating Agency and can be found on their website. All CPR courses must include a skills based demonstration.
B. First Aid – may be provided by the provider agency nurse, a certified trainer or a qualified internet provider.

C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Training on assisting members with ADLs – must be provided by the provider agency nurse or a documented specialist in this content area.
E. Abuse, Neglect and Exploitation - must be provided by the provider agency nurse or a documented specialist in this content area, or a qualified internet training provider.
F. HIPAA – training must include provider agency staff responsibilities regarding securing Protected Health Information - must be provided by the provider agency nurse or a documented specialist in this content area or a qualified internet training provider.
G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the provider agency nurse or a documented specialist in this content area, or a qualified internet training provider.
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to the member's special needs - must be provided by the provider agency nurse or a documented specialist in this content area.

Specialized Family Care Providers who are providing Personal Care Services must have a home that meets the definition of a Specialized Family Care Home as established by the Bureau for Children and Families (BCF) and must be certified by BCF, or its contractor, initially and annually thereafter. All training documentation necessary to be a certified Specialized Family Care Home must be up-to-date in accordance with the Bureau for Children and Families' Specialized Family Care policy manual.

517.8.1 ANNUAL STAFF TRAINING

CPR, First Aid, OSHA, Abuse, Neglect, Exploitation and HIPAA training must be kept current.

A. CPR is current as defined by the terms of the certifying agency.
B. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, current is defined by the terms of that entity. If provided by the provider agency nurse certified CPR instructor, must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (Example: if First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.)
C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)

In addition, four hours of training focused on enhancing direct care service delivery knowledge and skills must be provided annually. Member specific on-the-job-training can be counted toward this requirement.

517.8.2 TRAINING DOCUMENTATION

Documentation for training conducted by the provider agency nurse or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee. Training documentation for internet based training must include the person's name, the name of the internet provider and either a certificate or other documentation proving successful completion of the training. A card from the American Heart Association, the American Red Cross or other Operating Agency approved training entity is acceptable documentation for CPR and First Aid. All documented evidence of training for each direct care employee must be kept on file by the Personal Care provider and be available, upon request, for review by BMS or the Operating Agency. The documented evidence of training requirements for Specialized Family Care providers must be kept on file by the Bureau for Children and Families or their contractor and be available, upon request, for review by BMS or the Operating Agency.

517.9 REGISTERED NURSE QUALIFICATIONS

An RN must be employed by a certified Personal Care provider and have a current West Virginia RN license. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present. (For example – if an employee has been with the provider for three years – documentation of licensure must be present for all three years.) All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information,*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing Personal Care services meet the minimum qualifications. The Office of Inspector General (OIG) Medicaid Exclusion List must be checked for every RN employee prior to employment and monthly thereafter. A provider cannot employ an RN on the OIG Medicaid Exclusion List. This list can be obtained at http://exclusions.oig.hhs.gov.

517.10 CRIMINAL INVESTIGATION BACKGROUND CHECKS (CIB)

For the Personal Care Program the Criminal Investigation Background (CIB) check consists of three things:

1. A fingerprint based criminal history check conducted by the WV State Police contracted entity;
2. A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities List (Medicaid Exclusion List), CNA Registry, Board of Nursing; and
3. A check of the WV DHHR Protective Services Record.

At a minimum, a state level CIB check which includes a fingerprint check must be conducted by the West Virginia State Police contracted entity initially and again every three years for all Personal Care staff who have direct access to members. If the prospective employee has lived out of state within the last five years, he/she must initiate an FBI background check.

Prior to providing any Personal Care service, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. “Initiated” means the prospective employee has had a live fingerprint scan taken at an approved location, or if submitting hard copies of fingerprints, the day the copies are mailed for processing. Personal Care providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing Personal Care services cannot be considered to provide services if ever convicted of:

A. Abduction;
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery;
C. Any type of felony battery;
D. Child/adult abuse or neglect;
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation;
F. Felony arson;
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
H. Felony drug related offenses within the last 10 years;
I. Felony DUI within the last 10 years;
J. Hate crimes;
K. Kidnapping;
L. Murder/ homicide;
M. Neglect or abuse by a caregiver;
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct;
O. Purchase or sale of a child;
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
Q. Healthcare fraud; and
R. Felony forgery.

If aware of a recent conviction or change in status appropriate action must be taken and BMS notified about the change.

The Medicaid Exclusion List must be checked for every provider agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All Personal Care provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and

Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the *DHHR Bureau for Children and Families, Division of Children and Adult Services* or at http://www.wvdhhr.org/bcf/. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the provider agency staff's personnel file.

All payments for services provided by excluded individuals will be recovered by BMS.

517.11 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the Personal Care Program with 30 calendar days written notification of voluntary termination. The written termination notification must be submitted to the BMS fiscal agent and to the Operating Agency. The provider must provide the Operating Agency with a complete list of all current Personal Care members that will need to be transferred.

The Operating Agency will contact the members and assist them with acquiring services through another Personal Care provider.

A joint visit, if possible, with the member will be made by both the provider agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the Operating Agency.

The provider agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible.

517.12 INVOLUNTARY AGENCY CLOSURE

BMS may terminate a provider from participation in the Personal Care Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Personal Care Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to *Common Chapter 800(A), General Administration, and Common Chapter 800(B), Quality and Program Integrity* for more information on this procedure.

517.13 ADDITIONAL SANCTIONS

If BMS or the Operating Agency receives information that indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the provider information list on the Operating Agency website until the issues are addressed to the

satisfaction of BMS. Health and safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

517.14 INCIDENT MANAGEMENT

Personal Care providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to prevent harm to the health and safety of all members served. Incidents shall be classified by the provider as one of the following:

- **Abuse/Neglect or Exploitation -** Anyone providing services to a Personal Care member who suspects an incidence of abuse or neglect, as defined in *Chapter 517.1* must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-372-6513, 7 days a week, 24 hours day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within forty-eight (48) hours following the verbal report. An Adult Protective Services (APS) or a Child Protective Service (CPS) Worker may be assigned to investigate the suspected or alleged abuse.

- **Critical incidents** are incidents with a high likelihood of producing real or potential harm to the health and welfare of the Personal Care member. These incidents include, but are not limited to, the following:

    - Attempted suicide, or suicidal threats or gestures.
    - Suspected and/or observed criminal activity by members, members' families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
    - An unusual event such as a fall or injury of unknown origin requiring medical intervention, if abuse and neglect is not suspected.
    - A significant interruption of a major utility, such as electricity or heat in the member's residence, which compromises the health or safety of the member.
    - Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
    - Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
    - Unsafe physical environment in which the personal care direct care staff and/or other provider staff are threatened or abused, and the staff's welfare is in jeopardy.
    - Disruption of the delivery of Personal Care services, due to involvement with law enforcement authorities by the Personal Care member and/or others residing in the member's home that compromises the health or safety of the member.

- Disruption of the delivery of Personal Care services, due to involvement with law enforcement authorities by the direct care staff that compromises the health and safety of the member.
- Medication errors by a member or of his/her family member that is providing care that compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that compromises the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, which compromises the health or safety of the member.
- Any incident attributable to the failure of Personal Care provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS) or Child Protective Services (CPS).

- **Simple incidents** are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse, neglect or exploitation. Examples of simple incidents include, but are not limited to, the following:

  - Minor injuries of unknown origin with no detectable pattern.
  - Dietary errors with minimal or no negative outcome.

517.14.1 INCIDENT MANAGEMENT DOCUMENTATION AND INVESTIGATION PROCEDURES

Until such time that the WV Incident Management System is available to Personal Care providers, the Incident Report form must be completed within incident reporting timeframes for each member incident that occurs. Completed incident reports must be placed in an agency administrative file and must be available for review by the Operating Agency.

The Provider Agency Director or designated Registered Nurse will immediately review each incident report. All critical, abuse, neglect or exploitation incidents must be investigated by a Registered Nurse. All incidents involving abuse, neglect and /or exploitation must be reported to Adult Protective Services (APS) or Child Protective Services (CPS) within mandated time frames. An Incident Report documenting the outcomes of the investigation must be completed and submitted to the Operating Agency within 14 calendar days of the incident.

When the WVIMS is available to Personal Care providers, the Incident Report must be entered into the WVIMS within 24 hours of learning of the incident and the follow up must be entered within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file.

Providers are to report monthly if there were no incidents in the WV IMS. Until such time that the WV IMS is available, the provider must compete the No Monthly Incidents form and place in the agency administrative file.

The WVIMS does not supersede the reporting of incidents to APS or CPS. At any time during the course of an investigation, should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS or CPS.

A provider is responsible for investigating all incidents, including those reported to APS or CPS. If requested by APS or CPS, a provider shall delay its own investigation and document such request in the online WVIMS.

517.14.2 INCIDENT MANAGEMENT TRACKING AND REPORTING

Providers must review and analyze Incident Reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the providers Quality Management Plan. The Quality Management Plan must be made available to the Operating Agency monitoring staff at the time of the provider monitoring review or upon request.

517.15 PERSONAL CARE SERVICES

Personal Care services are medically necessary activities or tasks ordered by a physician, which are implemented according to a Nursing Plan of Care developed and supervised by an RN. These services enable people to meet their physical needs and be treated by their physicians as outpatients, rather than on an inpatient or institutional basis. Personal Care services can be provided on a continuing basis or on episodic occasions: Services must be:

- Prescribed by a physician on the 2000 Pre-Admission Screening (PAS) tool;
- Necessary to the long-term maintenance of the member's health and safety;
- Provided pursuant to a Nursing Plan of Care developed and monitored by an RN;
- Rendered by an individual who has met the basic training requirements of this manual; and
- Prior authorized by BMS's UMC

517.16 LOCATION OF SERVICES

Personal Care Services may be delivered in the member's home, place of employment or in the community. Personal Care hours provided in the community may not exceed 20 hours per month. Hours can be used to assist the member with completion of essential errands and medical appointments.

Personal Care Services may be provided to assist eligible individuals to obtain and retain competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability perform daily activities on and off the job; these would include

activities that the individual would typically perform if he/she did not have a disability. Locations for obtaining employment may include employment agencies, human resource offices, accommodation preparation appointments, and job interview sites.

Personal Care services cannot be provided in a hospital, nursing facility, ICF/IDD site, I/DD Waiver group homes with 4 or more members, I/DD Waiver Intensively Supported Setting (ISS) homes, or any other settings in which personal assistance and/or nursing services are provided. This exclusion does not include I/DDW, ADW or TBIW member's natural homes or Specialized Family Care Homes.

517.16.1 ASSISTED LIVING RESIDENCES AND GROUP RESIDENTIAL FACILITIES

Generally, Personal Care services may not be provided in assisted living residences or in group residential facilities. However, there may be instances where the provision of Personal Care services in these types of facilities would be allowed. Before providing services in assisted living residences and/or group residential facilities the following criteria must be met:

A. Medicaid Personal Care services shall not duplicate or replace those services for which a provider is required by law or regulation to provide. By definition, assisted living residences and group residential facilities must provide a certain level of personal care services; therefore these services cannot be replaced or duplicated. This includes private pay facilities.

B. If a Medicaid member who resides in an assisted living residence or a group residential facility requests Personal Care services the following documentation must be in the member chart:

    a. A detailed itemization of all services the facility must provide according to state regulations or contract;
    b. A detailed itemization of all services the Personal Care provider will be undertaking for the member and why the additional services are necessary.
    c. This information must be submitted to the UMC as part of the prior authorization process.

517.17 SERVICES AND/OR COSTS NOT ELIGIBLE FOR REIMBURSEMENT UNDER PERSONAL CARE SERVICES

A. Room and Board Services including the provision of food, shelter, maintenance and supplies.
B. Personal Care services which have not been certified by a physician on a PAS or are not in the approved Plan of Care.
C. Hours which have not received prior authorization.
D. Supervision and other activities that are considered normal child care that is appropriate for a child of a similar age.

517.18 FAMILY MEMBER RESTRICTION

Personal Care Services cannot be provided by a member's spouse or parents of a minor child (under age 18) for purposes of reimbursement by Medicaid.

517.19 MEMBER ELIGIBILITY

Applicants for the Personal Care Program must meet all of the following criteria to be eligible for the program:

A. Be a resident of West Virginia. The individual may be discharged or transferred from a nursing home or other institution in any county of the state, or in another state, as long as his/her residence is in West Virginia.
B. Be approved as medically eligible as described in *Chapter 517.19.*
C. Meet Medicaid financial eligibility criteria for the program as determined by the county DHHR office.

517.19.1 MEDICAL ELIGIBILITY DETERMINATION

The Pre-Admission Screening (PAS) is used to certify an individual's medical eligibility for Personal Care service. The PAS may be completed by either an RN or a physician; however, it must be signed and dated by a physician. The PAS is valid for 60 days after the date of the physician's signature. If services have not begun within that 60 day period a new PAS must be conducted. A Physician Certification Form is needed if the PAS was completed by an RN. This form and the PAS must both be in the member's chart.

Following the physician's signature, the RN must sign and date the PAS and submit it to the UMC who will determine medical eligibility (*517.20 A*). The effective date of medical eligibility is the date of the physician's signature. If found ineligible, the UMC will follow procedures outlined in 517.20 B. The PAS must be completed annually in accordance with the member's anchor date to certify continuing medical eligibility for services.

517.19.2 MEDICAL ELIGIBILITY CRITERIA FOR PERSONAL CARE SERVICES

An individual must have three (3) deficits as described on the Pre-Admission Screening Form (PAS) to qualify medically for the Personal Care Program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	**Observed Level**	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)

Section	Observed Level	
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, bowel Continence, Bladder	Level 3 or higher; (must be incontinent)
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transferring	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)

An individual may also qualify for Personal Care services if he/she has two (2) functional deficits identified as listed above (items refer to PAS) and any one (1) or more of the following conditions indicated on the PAS:

Section	Observed Level
#24	Decubitus; Stage 3 or 4
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
#28	Individual is not capable of administering his/her own medications.

517.19.3 SERVICE LEVEL CRITERIA

There are two Service Levels for Personal Care services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#24	Decubitus - 1 point
#25	1 point for b., c., or d.
#26	Functional Abilities: Level 1 - 0 points Level 2 - 1 point for each item **a** through **i**. Level 3 - 2 points for each item **a** through **m**

Section	Description of Points
	i (walking) must be at Level 3 or Level 4 in order to get points for **j** (wheeling) Level 4 – 1 point for **a**, 1 point for **e**, 1 point for **f**, 2 points for **g** through **m**
#27	Professional and Technical Care Needs - 1 point for continuous oxygen.
#28	Medication Administration - 1 point for b. or c.

Total number of points possible is 30.

517.19.4 SERVICE LEVEL LIMITS

The service limit for T1019 Personal Care (Direct Care) Level 1 Services is sixty (60) hours per calendar month. In the event that the PAS reflects fourteen (14) or more points as described in 517.19.3, and the member assessments fully document the need, the Personal Care Agency may request additional hours at Service Level 2.

Service Level	Points Required	Range of Hours Per Month
1	0 – 13	0 - 60
2	14-30	61-210

517.20 RESULTS OF PAS EVALUATION

A. APPROVAL

All requests for Personal Care services (Levels I and 2) must be submitted prior to the UMC and include:

- The completed APS Healthcare Prior Authorization Fax sheet;
- The PAS with the dated physician's signature and the dated provider agency's RN signature;
- The Physician Certification Form; and
- The number of months services are needed for up to a maximum of twelve (12) months or until the current PAS expires, whichever is less.

Additionally, if requesting a Service Level 2 prior authorization request, the provider must submit to the UMC:

- The completed APS Prior Authorization Fax sheet;

- The PAS with the dated physician's signature and the dated provider agency's RN signature;
- The Physician Certification form;
- Nursing Assessment and Plan of Care
- Other documentation the RN feels is relative to making a determination for a Service Level 2;
- The total number of units needed per month; and
- The number of months services are needed for up to a maximum of twelve (12) months or until the current PAS expires, whichever is less.

Service Level 1 requests will be reviewed by the Utilization Management Contractor (UMC) to ensure the three (3) required deficits in ADL's and all signatures and dates are present. Service Level 2 requests will be reviewed by UMC RN to confirm the presence of the three (3) required deficits in ADL's, and to confirm the need for Service Level 2 care. The UMC will notify the provider agency in writing within 5 working days of receipt of the request, their decision and if approved provide a prior authorization number.

Once authorization is received from the UMC, the Personal Care provider must complete the member's Personal Care Assessment and Personal Care Plan of Care, based on identified needs and member preferences, and initiate direct care services within 10 calendar days. At the time the provider receives the PAS from the physician, the RN must start to document actions on the Personal Care Initial Contact Form.

B. DENIAL

The Provider agency must submit the PAS to the Utilization Management Contractor (UMC). If the UMC determines the applicant/member does not meet medical eligibility or does not meet the criteria for the requested Service Level, the UMC will provide the applicant/member with a denial letter within 5 working days of the decision date. The letter will include: why he/she does not meet medical eligibility, a copy of the PAS, the applicable Personal Care policy manual section(s), notice of free legal services, a Request for Hearing Form to be completed if the applicant wishes to contest the decision and specific timeframes for filing an appeal.

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, services cannot start earlier than the date of the hearing decision.

517.21 COVERED SERVICES

The following information describes the Personal Care Services and activities which are reimbursable by Medicaid. These apply to all Personal Care providers unless otherwise noted. For individuals who will receive Personal Care services as well as a Medicaid Waiver service, please see *Chapter 517.22, Provision of Dual Services.*

517.21.1 INITIAL MEMBER ASSESSMENT/REEVALUATION

Procedure Code: T1001
Service Unit: Event
Limit: 1 per year
Prior Authorization: No

Required Documentation: An initial or annual PAS signed and dated by a physician and the Agency RN, a Personal Care Assessment and a Personal Care Plan of Care. All activities must be conducted by the provider agency RN.

A. Review and submit the physician signed and dated PAS.
B. Conduct the initial and annual person centered face-to-face Personal Care Assessment, (except for dual services).
C. Development of the initial and annual Personal Care Plan of Care. The Plan of Care must be developed with the member and/or his/her legal representative and must address the member's needs and preferences.

517.21.2 ONGOING RN ASSESSMENT AND CARE PLANNING

Procedure Code: T1002
Service Unit: 15 minutes
Limit: 6 units per month
Prior Authorization: No

Required Documentation: A six month Personal Care Assessment (except for dual service members), a six month Personal Care Plan of Care, the Personal Care RN member contact form and the Personal Care Monthly Report.

A. A person centered face-to-face Personal Care Assessment must be conducted every six months. Additional Personal Care Assessments may be conducted if the member's condition indicates a need. The Personal Care Assessment must be signed and dated by the RN and the member (or legal representative).
B. The Plan of Care must consider any informal support (i.e. family, friends or community supports) that are available to address the member's needs identified on the PAS and the Personal Care Assessment. The Plan of Care must be modified as necessary to address changes in the member's condition.
C. Environmental maintenance (examples: housekeeping, washing dishes, laundry, etc.) may not exceed one-third (1/3) of the time spent providing Personal Care services.
D. The RN must monitor and assess the quality and appropriateness of the direct care service and assure that it is provided according to the Plan of Care.
E. The RN must review and sign the Personal Care Plan of Care once it is completed by the member (or legal representative), and the direct care worker, certifying all activities were performed as needed and met the member's preferences. One-on-one training of

the direct care worker by the RN is reimbursable if the purpose of the one-on-one training is to instruct the direct care staff in a specific care technique for the member. The RN must document the reason and the specific training provided on the RN contact form.

F. Submit the Personal Care Monthly Report to the Operating Agency by the sixth business day of the month.

Although the goal is to provide assistance to an individual who cannot carry out activities of daily living, when assessing and care planning, the RN assures that this goal is balanced with the goal of promoting independence and encouraging the highest possible level of function for the individual.

517.21.3 PERSONAL CARE SERVICES (DIRECT CARE SERVICES)

Procedure Code: T1019
Service Unit: 15 Minutes
Service Limit: 210 hours per month or 840 units
Prior Authorization: Yes

Required Documentation: Plan of Care signed and dated by direct care worker, provider agency RN and member (or legal representative) with a tentative schedule outlining the dates/times when the member will receive Personal Care services.

The functions of the Personal Care direct care staff include providing direct care services as defined by the Plan of Care, recording services and time spent with the member and communicating to the RN any member changes.

Personal Care direct care staff duties and responsibilities as described in the Plan of Care may include:

A. Assist member with ADLs, in the home or community.
B. Assist member with environmental tasks necessary to maintain the member in the home.
C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs) — Examples: grocery shopping, medical appointments, Laundromat, and trips to the pharmacy. The member may accompany the personal care direct care staff on these errands.
D. If ADLs or IADLs tasks are provided in the community, the amount may not exceed 20 hours per month.
E. Assist members in obtaining or retaining competitive employment of at least 40 hours a month by providing Personal Care services in locations for obtaining employment such as employment agencies, human resource offices, accommodation preparation appointments, job interview sites, and work sites.
F. Report significant changes in member's condition to the RN.
G. Report any incidents to the RN. (Examples: member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)

H. Report any environmental hazards to the RN. (Examples: no heat, no water, pest infestation or home structural damage).
I. Prompt for self-administration of medications.
J. Maintain records as instructed by the RN.
K. Perform other duties as assigned by the RN within program guidelines.
L. Accurately complete Personal Care Plan of Care and other records as instructed by the RN.

Personal care direct care staff cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Plan of Care. Functions/tasks that cannot be performed include, but are not limited to, the following:

A. Care or change of sterile dressings.
B. Colostomy irrigation.
C. Gastric lavage or gavage.
D. Care of tracheostomy tube.
E. Suctioning.
F. Vaginal irrigation.
G. Administer injections, including insulin.
H. Administer any medications, prescribed or over-the-counter.
I. Perform catheterizations, apply external (condom type) catheter.
J. Tube feedings of any kind.
K. Make medical judgments or give advice on medical or nursing questions.
L. Application of heat.

517.22 PROVISION OF DUAL SERVICES

Individuals who are receiving either *Aged and Disabled Waiver (ADW)* services, *Intellectual/Developmental Disabilities Waiver (I/DDW)* services or *Traumatic Brain Injury Waiver (TBIW)* services may also receive Personal Care Services, if they have unmet direct support needs and meet Personal Care criteria.

517.22.1 DUAL SERVICE PROVISION FOR ADW MEMBERS

Approval of the provision of both ADW and Personal Care services to the same person will be considered if the following criteria are met:

A. An ADW member must be receiving services at Service Level D.
B. The Personal Care RN may use the current PAS used to determine ADW eligibility. However, it must be reviewed to assure the information is current and reflective of the member's needs. If not, the Personal Care RN should complete a new one.
C. For members who receive services from an ADW provider agency the ADW Member Assessment, and the ADW Nursing Plan of Care must be used in order to determine member need of Personal Care services. For members who receive services through Personal Options the Participant Directed Service Plan must be used to determine

member need of Personal Care services. A Personal Care RN Assessment is not required.

D. For members who are receiving ADW services through an ADW provider agency the coordination of the dual service request is the responsibility of the Case Manager. This includes coordinating the planning meeting which includes the ADW RN, the Personal Care RN and the member (or legal representative).
E. For members who are receiving ADW services through Personal Options the initiation of dual service request is the responsibility of the Resource Consultant. Coordination of the dual services is the responsibility of the Personal Care RN. This includes coordinating the planning meeting with the ADW member (or legal representative), the Resource Consultant, and the Personal Care RN.
F. The Personal Care RN is responsible for development of the Personal Care Nursing Plan of Care and for submitting the prior authorization to the UMC. There must be a Personal Care Nursing Plan of Care and a Participant Directed Service Plan. Both plans must be coordinated between the two agencies providing direct services to ensure that services are not duplicated. Personal Care and ADW Personal Assistance/Homemaker services cannot be provided during the same hours on the same day. A service planning meeting between the Resource Consultant, the Personal Care RN and the Case Manager, if applicable, must be held with the member in the member's residence and documented on the "Request for Dual Service Provision" form.
G. The Resource Consultant or the ADW Case Manager, if applicable, will be responsible for assuring that the two programs are being administered according to the member needs. The Personal Care Nursing Plan of Care with a tentative schedule outlining when all direct support services (PC and Waiver) are expected to be delivered must be attached to the Plan of Care. At no time can a duplication of services occur.

517.22.2 DUAL SERVICE PROVISION FOR I/DDW MEMBERS

Approval of the provision of both I/DDW and PC Services to the same person will be considered if the following criteria are met:

A. A I/DDW member must be utilizing the maximum number of Direct Care Service hours in the Waiver program available based on the member's age and type of residence prior to applying for Personal Care. See the *I/DDW* manual (*Chapter 513*) for the definition of which services are considered to be Direct Care Services AND must have an ICAP Service Score of 1, 2, 3 or 4. Individuals in 24-hour staffed settings are not eligible for Personal Care.
B. A PAS must be completed as outlined in *Chapter 517.19 and all of its subparts* to determine medical eligibility for Personal Care services. When determining the need for Personal Care services the PAS, the ICAP as completed by the I/DD Waiver Operating Agency and the WV-BMS I/DD/05 (Individual Program Plan) must be used.
C. A Personal Care Plan of Care must be developed between the agencies providing direct care services to ensure that services are not duplicated. Personal Care and I/DDW services cannot be provided during the same hours on the same day. A service planning meeting between the I/DDW Service Coordinator and the Personal Care RN must be

held with the member and legal representative (when applicable) in the member's residence and documented on the Request for Dual Service Provision form.

D. The I/DDW Service Coordinator is responsible for coordination of the dual service request. This includes coordinating the planning meeting which must include the I/DDW Service Coordinator, the Personal Care RN, the member (or legal representative). The Service Coordinator must attach the Plan of Care to the IPP and upload the plan into the members file in CareConnection®.
E. The Personal Care RN is responsible for completing the PAS, development of the Personal Care Plan of Care and submitting the prior authorization to the UMC.
F. The I/DDW Service Coordinator will be responsible for assuring that the two programs are being administered according to the member needs and the respective plans of care. A tentative schedule will be included in the Plan of Care. At no time can a duplication of services between the two programs occur.

517.22.3 DUAL SERVICE PROVISION FOR TBIW MEMBERS

Approval of the provision of both Traumatic Brain Injury Waiver services and PC Services to the same person will be considered if the following criteria are met:

A. A TBIW member must need more than the maximum Personal Attendant Services hours in the Waiver program prior to applying for Personal Care and has direct care needs that cannot be met by the Waiver.
B. The RN may use the current PAS completed by the TBI Waiver Operating Agency to determine medical eligibility for the TBIW services. However, it must be reviewed to assure the information is current and reflective of the member's needs. If not, the Personal Care RN should complete a new one. When determining the need for Personal Care services the PAS and the TBI Member Assessment and TBIW Service Plan must be used. Personal Care services must be reflected on the member's TBIW Service Plan and tentative schedule.
C. For members who are receiving TBIW service through a TBI provider agency, the coordination of the dual service request is the responsibility of the Case Manager. This includes coordinating the planning meeting with the Personal Care RN, the Case Manager and the member and/or legal representative. If the member chooses not to have a Case Manager, the Operating Agency may assist the member in fulfilling that role.
D. For members who are receiving TBIW services through Personal Options the initiation of dual service request is the responsibility of the Resource Consultant. Coordination of the dual services is the responsibility of the Personal Care RN. This includes coordinating the planning meeting with the TBIW member (or legal representative), the Resource Consultant, and the Personal Care RN.
E. The Personal Care RN is responsible for development of the Personal Care Nursing Plan of Care and for submitting the prior authorization to the UMC.
F. There must be a Personal Care Nursing Plan of Care and a Participant Directed Service Plan. Both plans must be coordinated between the two agencies providing direct services to ensure that services are not duplicated. Personal Care and TBIW Personal

Attendant services cannot be provided during the same hours on the same day. A service planning meeting between the Resource Consultant, the Personal Care RN and the Case Manager, if applicable, must be held with the member in the member's residence and documented on the "Request for Dual Service Provision" form.

G. The Resource Consultant or the TBIW Case Manager, if applicable, will be responsible for assuring that the two programs are being administered according to the member needs. The Personal Care Nursing Plan of Care must include a tentative schedule outlining when all direct support services (PC and Waiver) are expected to be delivered. At no time can a duplication of services between the two programs occur.

517.23 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Personal Care agencies must communicate in writing to each member (or legal representative) their right to:

A. Transfer to a different provider agency.
B. Address dissatisfaction with services through the provider agency's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding Personal Care services.
G. Access to all of their files maintained by providers.

And their responsibility to:

H. Notify the Personal Care provider within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care.
K. Cooperate with all scheduled in-home visits
L. Notify the Personal Care provider of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the Personal Care provider of any change of medical status or direct care need.
N. Maintain a safe home environment for the Personal Care provider to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the Personal Care provider.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Control Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the Personal Care provider or the Adult Protective Services hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

517.24 TRANSFER TO DIFFERENT AGENCY

A Personal Care member may request a transfer to another provider agency at any time. The Operating Agency will assist with transfers if needed.

Transferring Provider Agency Responsibilities:

- To provide the receiving agency with the current PAS, the Member Assessment (Personal Care or ADW, or TBIW), Personal Care Plan of Care, Individual Program Plan, ICAP (when applicable) and Participant Directed Service Plan (when applicable). In addition, the transferring provider agency should share other documents as needed.
- To maintain all original documents for monitoring purposes.
- Continue to provide services to member until transfer process is completed.

Receiving Provider Agency Responsibilities:

- Develop the Personal Care Plan of Care within seven (7) business days.

Note: The existing Personal Care Plan of Care from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new Personal Care Plan of Care to prevent a gap in services.

517.25 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by the Operating Agency:

A. No services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the direct care staff and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:

    1) The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal assistant direct care staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    2) The member or other household members display an abusive use of alcohol and/or drugs or engages in the manufacture, buying and/or selling of illegal substances.
    3) The physical environment is either hazardous or unsafe.

C. The member is persistently non-compliant with the Personal Care Nursing Plan of Care.

D. Member no longer desires services (must include a signed statement from the member (or legal representative) indicating they no longer desire services). If a signature is not attainable due to death or other reason, that must be documented.

If the closure is due to an unsafe environment the Personal Care provider will contact the Operating Agency for assistance. The provider must notify APS or CPS if an unsafe situation warrants such notification.

The Request for Discontinuation of Services Form must be submitted to the Operating Agency. The Operating Agency will review all requests for a discontinuation of services. If it is an appropriate request, and the Operating Agency approves the discontinuation, the Operating Agency will send notification of discontinuation of services to the member (or legal representative). Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the Operating Agency notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment, services may be discontinued immediately.

All discontinuation of services (closures) must be reported on the Personal Care Monthly Report to the Operating Agency.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Personal Care Monthly Report:

A. Death
B. Moved Out of State
C. Medically Ineligible
D. Financially Ineligible

517.26 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance about the provision of services. All Personal Care providers will have a written member grievance procedure. Providers will provide members grievance procedure information and grievance forms at the time of application and annual medical eligibility re-evaluation. These forms will also be provided upon request by the member in addition to the time of application and the annual re-evaluation.

The grievance procedure consists of two levels:

A. **Level One: Personal Care Provider**
A Personal Care Provider has ten (10) business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone with the member or their legal representative. The meeting will be conducted by the provider

agency director or their designee. The provider has five (5) days from the date of the meeting to respond in writing to the grievance.

If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the Operating Agency for a Level Two review and decision.

B. **Level Two: Operating Agency**
If a Personal Care provider is not able to address the grievance in a manner satisfactory to the member, the member may request a Level Two review. The Operating Agency will, within ten (10) business days of the receipt of the Member Grievance Form, contact the member (or legal representative if applicable) and the Personal Care provider to review the Level One decision, and issue a Level Two decision. Level Two decisions are based on Medicaid policy and/or health and safety issues.

518.00 How to Obtain Information

Service	Person or Company	Phone Number	Fax Number
Operating Agency	Bureau of Senior Services 1900 Kanawha Boulevard East Charleston, WV 25305	304-558-3317 877-987-3646	304-558-6647
Personal Care Program Manager	Bureau for Medical Services	304-356-4913	304-558-4398
Fiscal Agent	Molina Medicaid Solutions	304-888-483-0793 **(for providers)** 304-348-3380 **(for members)**	304-348-3380
Utilization Management Contractor: **Prior Authorizations**	Innovative Resource Group LLC (IRG) d/b/a APS Healthcare	866-385-8920	866-521-6882
UMC- Dual Services Provision Requests for AD Waiver and I/DD Waiver	IRG d/b/a/ APS Healthcare	800-982-6334 **(Option 3)**	866-212-5053
UMC-Dual Services Provision Requests for TBI Waiver	IRG d/b/a/ APS Healthcare	866-385-8920	866-521-6882
UMC-Specialized Family Care Home	IRG d/b/a/ APS Healthcare	866-385-8920	866-521-6882
Personal Options	Public Partnerships	888-775-9801	304-296-1932